UCB PATIENT ASSISTANCE PROGRAM APPLICATION

Inspired by **patients.** Driven by **science.**

PHONE (877) 785-8906 **FAX** (855) 880-5262

The UCB Patient Assistance Program is currently accepting applications for the following medications:

BIMZELX® (bimekizumab-bkzx)
BRIVIACT® (brivaracetam) CV
CIMZIA® (certolizumab pegol)
NAYZILAM® (midazolam) nasal spray CIV
NEUPRO® (rotigotine transdermal system)

ELIGIBILITY

Assistance for the above-referenced UCB medications may be available to patients with a valid prescription from a U.S. licensed healthcare prescriber. This program is not intended for clinics, hospitals, and/or other institutions. ***All information provided in this application is subject to verification.***

The *minimum* eligibility requirements are as follows:

- Patient must reside in the United States, the District of Columbia, or a U.S. Territory.
- Patient must be uninsured, underinsured, or, if insured, have significant financial hardship despite insurance coverage.
- Insured patients with approved coverage who cannot afford their medication will be considered only after exhausting all other coverage options.
- CIMZIA patients with any state, federal, or government-funded healthcare program, including but not limited to Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE/CHAMPUS, any state prescription drug assistance program, or the Government Health Insurance Plan available in Puerto Rico, are not eligible for the UCB Patient Assistance Program.
- All applications must include a valid prescription from a U.S. licensed healthcare prescriber.
  Prescriptions for BRIVIACT CV and NAYZILAM CIV must be signed by a MD or DO in compliance with Texas Pharmacy Regulations, as the Patient Assistance Program (PAP) pharmacy is located in Texas.
- A patient's total gross household income cannot exceed 500% of the Federal Poverty Limit (FPL).
  Detailed information on the current FPL can be found at https://www.healthcare.gov/glossary/federal-poverty-level-FPL
- If there is NO household income, please submit a letter with this application (signed and dated by the patient or patient's personal representative) to explain that the patient receives no income.
- Additional product specific eligibility criteria may apply.
- Patient Assistance Program Business Rules and Program Eligibility are subject to change at the discretion of UCB without notification.

INSTRUCTIONS

If you believe you meet the minimum requirements for program eligibility, please complete the Patient Section, then have your healthcare provider complete the Prescriber Section. If you believe you do not meet the minimum requirements listed above, you may not qualify for the UCB Patient Assistance Program; however, you may contact UCBCares® by calling 1-844-599-CARE (2273) to see if there are other financial resources available to you.

STEP 1: Patient, or patient personal representative, completes PATIENT APPLICATION

STEP 2: Healthcare Provider completes PRESCRIBER APPLICATION and PRESCRIPTION

Complete this application form and submit to:

MAIL
UCB, Inc.
UCB Patient Assistance Program
2730 S. Edmonds Lane, Suite 300
Lewisville, TX 75067

FAX
(855) 880-5262

EMAIL
ucb-pap@cardinalhealth.com

Please do NOT submit additional or unrequested medical information, chart notes, or supporting medical documentation.

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PERSONAL INFORMATION

Please Select: ☐ New Patient ☐ Re-Enrollment

First Name: _____ Last Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Email Address: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Office ☐ Other: _____

Preferred Language: _____ Social Security # _____

Does patient reside in the U.S.? ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

*If requesting **BRIVIACT CV** or **NAYZILAM CIV**, please provide the following information found on a current official U.S. government ID:*

ID Type: _____ State: _____

ID Number: _____

ALTERNATE CONTACT

By providing this information, you authorize UCB program administrators to share or discuss your patient health information (PHI) with the person(s) listed below for purposes of determining your eligibility for and/or helping you access the above UCB medications through the UCB Patient Assistance Program. Please list no more than two (2) persons authorized to discuss your PHI with UCB program administrators. We will not be able to discuss your application or PHI with an individual(s) representing a third party , including, but not limited to, alternate funding programs. Please ensure any alternate contact provided, other than a family member or caregiver, is a legitimate healthcare professional or medical office staff member associated with your treating physician.

1

First Name: _____ Last Name: _____ Phone: _____

Email Address: _____ Relationship: _____

2

First Name: _____ Last Name: _____ Phone: _____

Email Address: _____ Relationship: _____

INCOME INFORMATION

Please include your **TOTAL GROSS ANNUAL HOUSEHOLD** income from all sources including but not limited to:

Salary/Wages/Dividends • Social Security • Supplemental Income • Disability Unemployment Compensation • Pension/Annuity • Alimony/Child Support • Rental Income

Total Gross Household Annual Income: $

You may be contacted by the UCB Patient Assistance Program to provide Proof of Income.

Number of persons DEPENDENT upon primary income within the household:
Including yourself, spouse/partner, other adults, dependents, etc.

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Patient Name: _____ Date of Birth: _____

PRESCRIPTION INSURANCE

Type of Insurance:

☐ Medicaid ☐ Medicare ☐ Commercial ☐ Other

If other please specify: _____

Insurance Name: _____

Insurance Phone #: _____

ID Number: _____

Group Number: _____

BIN Number: _____ PCN Number: _____

MEDICAL INSURANCE

Type of Insurance:

☐ Medicaid ☐ Medicare ☐ Commercial ☐ Other

If other please specify: _____

Insurance Name: _____

Insurance Phone #: _____

ID Number: _____

Group Number: _____

PLEASE INCLUDE A COPY OF INSURANCE CARDS WITH THIS APPLICATION

☐ **I am uninsured** and do not have health insurance at this time (prescription or medical).
You will be contacted by the UCB Patient Assistance Program to provide verbal confirmation of your insurance status.

Please do NOT submit additional or unrequested medical information, chart notes, or supporting medical documentation.

Fair Credit Reporting Act Authorization

I, the applicant named above, understand that I am providing "written instructions" to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB") under the Fair Credit Reporting Act authorizing UCB to obtain an investigative consumer report or other information from my credit profile solely for the purpose of determining my financial eligibility for the UCB Patient Assistance Program ("Program") (collectively, "Authorization"). I agree to provide additional financial documentation, in a timely manner, if requested by UCB to carry out the above activities. I further agree to allow the Program to contact me via mail, telephone, or email to perform these activities. Should an investigative consumer report be utilized, I will have the right to request a complete and accurate disclosure of the nature and scope of the investigation or other information requested and a written summary of my rights under the Fair Credit Reporting Act. This Authorization shall be valid for two (2) years from the date of the signature of this form (unless a shorter period is prescribed by law).

I understand that if I do not sign this Authorization or if I cancel it, I cannot participate in the Program. I further understand that I may cancel this Authorization at any time by (1) sending an email to PrivacyOptOut@ucb.com, or (2) mailing a letter to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080, stating that you wish to opt out of the Fair Credit Reporting Act Authorization for the UCB Patient Assistance Program, and including your First Name, Last Name, Date of Birth, ZIP Code and gender (as assigned at birth) for reference; however, this cancellation will not apply to any information already in use or disclosed through this Authorization. Otherwise, this Authorization will expire upon your withdrawal from the Program.

My signature below certifies that I have read and understand this document (or, if signed by my Personal Representative, that my Personal Representative has read and understands this document). I understand that I may request a copy of this Authorization once it has been signed.

SIGN HERE Signature of Patient or Patient Personal Representative: _____ Date: _____

Name of Patient or Patient Personal Representative (please print): _____

If signed by Patient Personal Representative, please provide your phone number, and indicate your authority to act on behalf of the Patient:

☐ Relative ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Court Appointed ☐ Other: _____

Patient Personal Representative Phone Number: _____

If patient personal representative has power of attorney for patient please include supporting documentation.

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Patient Name: _____ Date of Birth: _____

Patient Consent to Receive Communications

CHECK HERE ☐ I agree to receive communications from UCB's Patient Assistance Program (the "Program"), including but not limited to autodialed, prerecorded and/or artificial voice calls and autodialed text messages, at the phone number(s) I provided to offer enrollment support, insurance coverage and financial assistance resources and support, injection resources and support, treatment reminders, resources and support, and for other non-marketing purposes. If I have designated a personal representative, he or she also agrees hereby to receive such communications from the Program for the purposes described above at the phone number(s) provided.

For text messages, message and data rates may apply. You will receive up to ten text messages per month. For questions, contact the UCB Patient Assistance Program Pharmacy at 877-369-6083. View the complete Terms of Use at https://m.snx.cardinalhealth.com/mterms.

I understand that I (and my personal representative, if applicable) may opt out of receiving text messages from the Program at any time by replying "STOP"; and for voice and text message communications by (1) sending an email to PrivacyOptOut@ucb.com, or (2) mailing a letter to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080, stating that you wish to opt out of receiving communications from UCB in connection with the UCB Patient Assistance Program and including your First Name, Last Name, Date of Birth, ZIP Code and gender (as assigned at birth) for reference.

Patient Authorization to Use/Disclose Health Information

By signing this Patient Authorization to Use/Disclose Health Information ("Authorization"), I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy that receives my prescription for a UCB medication), and other of my healthcare providers (together, "Providers") and each of my health insurers (together, "Insurers") to disclose information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and email addresses, telephone number, and date of birth (together, "Health Information"), to UCB, Inc. and its agents, service providers, contractors and representatives (together, "UCB"). My Health Information will be shared with UCB so that UCB may: (i) verify, investigate, assist with, and coordinate my access and coverage for an available UCB medication(s) through the UCB Patient Assistance Program with my Insurers and Providers; (ii) determine my eligibility for and help me access an available UCB Medication(s) through the UCB Patient Assistance Program; (iii) conduct market research and/or analyses or other commercial activity, including aggregating my Health Information with other data for such analyses; (iv) assist with analysis related to quality, efficacy, and safety for UCB medications; and (v) de-identify my Health Information for use for any purpose as permitted under applicable law.

I understand that I do not have to sign this Authorization and choosing not to sign will not affect my ability to receive treatment from my Providers or payment from my Insurers. However, if I do not sign this form, UCB may not be able to provide me with certain patient support. Once my Health Information has been disclosed to UCB, I understand that federal and/or state privacy laws may no longer protect this information. However, I understand that UCB and other parties authorized to receive my Health Information pursuant to this Authorization agree to protect my Health Information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I also understand that one or more Provider and/or Insurer may receive payment from UCB for disclosing my Health Information for some or all of the purposes listed above.

I understand that I (and my personal representative, if applicable) may revoke this Authorization at any time by (1) sending an email to PrivacyOptOut@ucb.com or (2) mailing a letter to UCBCares at 1950 Lake Park Drive, Smyrna, GA 30080, stating that you wish to revoke your Patient Authorization to Use/Disclose Health Information for the UCB Patient Assistance Program and including your First Name, Last Name, Date of Birth, ZIP Code and gender (as assigned at birth) for reference. I understand that by revoking my Authorization, UCB will no longer use or disclose my Health Information in connection with the UCB Patient Assistance Program and may not be able to provide me with certain patient support and, further, my revocation will not affect previous disclosures made pursuant to this Authorization.

This Authorization expires 2 years from the date it was signed unless a shorter period is mandated by the law of my state of residence, or unless otherwise revoked as outlined above. I understand that I have the right to receive a copy of this Authorization once it is signed.

SIGN HERE Signature of Patient or Patient Personal Representative: _____ Date: _____

Name of Patient or Patient Personal Representative (please print): _____

If signed by Patient Personal Representative, please provide your phone number, and indicate your authority to act on behalf of the Patient:

☐ Relative ☐ Guardian ☐ Power of Attorney (including for healthcare decisions) ☐ Court Appointed ☐ Other: _____

Patient Personal Representative Phone Number: _____

If patient personal representative has power of attorney for patient please include supporting documentation.

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PRESCRIBER INFORMATION

Please note that prescriptions for BRIVIACT CV and NAYZILAM CIV require a MD or DO signature in compliance with Texas Pharmacy Regulations

Prescriber Name: _____ Title: _____

DEA #: _____ NPI #: _____ State License #: _____

Practice Name: _____ Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Contact: _____ Email Address: _____

Office Contact Phone: _____ Office Contact Fax: _____

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of Birth: _____

Mailing Address: _____

_____

City: _____

State: _____ Zip Code: _____

Known Allergies: _____

_____

Concomitant Medications: _____

_____

PRESCRIPTION INFORMATION

To submit an electronic prescription, please select the following in your eRx system:
Sonexus Health Pharmacy Services (NPI # 1447680210)

☐ eRx submitted ☐ Initial Dose ☐ Maintenance Dose

Medication (brand name only):

_____

Quantity: _____ Strength: _____

Dosage: _____

Indication: _____ Refills: _____

Patient's Weight: _____ ☐ kg ☐ lbs

Directions: _____

_____

Please follow your state's prescribing guidelines for electronic prescriptions (if applicable). CA, MA, NC, & PR: Interchange is mandated unless prescriber writes "No substitutions". ATTN: NY and IA, please submit electronic prescription.

Please do NOT submit additional or unrequested medical information, chart notes, or supporting medical documentation.

By my signature below, I certify that (a) I am the healthcare professional who has prescribed the medication identified in this form; (b) I have made an independent judgment that the above medication is medically necessary; and (c) the information provided in this form is accurate to the best of my knowledge. I hereby authorize UCB, Inc., and its affiliates, agents, representatives, and service providers (together, "UCB") as my agent to transfer this prescription to the appropriate dispensing pharmacy. I further certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under Federal and applicable state privacy laws to release the patient's health information, including that contained on this form, to UCB solely for purposes relating to the UCB Patient Assistance Program so that UCB may: (i) verify, investigate, assist with, and coordinate the patient's access and coverage for an available UCB medication(s) through the UCB Patient Assistance Program with my Insurers and Providers; (ii) determine the patient's eligibility for and help the patient access an available UCB Medication(s) through the UCB Patient Assistance Program; (iii) conduct market research and/or analyses or other commercial activity, including aggregating my Health Information with other data for such analyses; (iv) assist with analysis related to quality, efficacy, and safety for UCB medications; and (v) de-identify the patient's Health Information for use for any purpose as permitted under applicable law. I also certify that I have obtained consent from the patient or the patient's authorized personal representative to be contacted by UCB using autodialed, prerecorded and/or artificial voice calls and autodialed text messages at the phone number(s) provided above for the above purposes. Finally, I give permission for UCB to contact me using autodialed, prerecorded and/or artificial voice calls and autodialed text messages at the phone number(s) I provided for the above purposes.

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE.
RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIPTION WILL NOT BE ACCEPTED.

SIGN HERE Prescriber Signature: _____ Date: _____